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ABSTRACT

This report discusses the roles of health, nutrition and informal education in the preschool education of children in southwest Ethiopia. Information for the report is drawn from data from a study of traditional maternity and child care in the Southern Shewa region of the country. Mother and child health is a priority in Ethiopian health planning. The 10-year health sector plan aims at a reduction of the infant mortality rate, an improvement in life expectancy, and a strengthening and expansion of services and programs. Elderly women in the region have sound knowledge about maternal health, deliveries, care and feeding of infants, and trado-pharmacological remedies. In the region, there is little attention to the preservation of beneficial nutritional practices, which are better than modern ones. Firsthand observations indicate that small children are given much attention by parents, siblings, and grandparents. During the first years of life, children play around their houses, often imitating adult life. Later, girls receive a practical education from their mothers. Women in the region usually speak three or four languages fluently, and children usually become bilingual at an early stage. During the past 15 years, a national preschool program has developed rapidly. (RJC)

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HEALTH, NUTRITION AND INFORMAL EDUCATION OF PRE-SCHOOL CHILDREN IN SOUTH-WEST ETHIOPIA

For the 21st International Conference
on Early Education and Development (0-6 years)
"Childhood in the 21st Century"
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HEALTH, NUTRITION AND INFORMAL EDUCATION OF PRE-SCHOOL CHILDREN IN SOUTH-WEST ETHIOPIA

1. Introduction.

There are three areas that are important for early child care and early child development, namely health, nutrition and early informal education. Children in developing countries need special attention, as they are often handicapped by a lack of proper nutrition and also suffer from ill-health, having few or no opportunities to obtain proper health care. Without access to these pre-conditions their future educational achievement is gravely affected.

Scrimshaw (1967), Winick (1969) and Negussie (1988a,1988b,1989) discuss the importance of taking health and nutrition into account when discussing child development and future educational achievement, and emphasizes that already the fetal stage is crucial for a child's development. Damage during the fetal stage and the first months of life causes irreparable damage to the human brain, which lowers the level of educational success later in life. Also history teaches us that child health and child development is closely related to the mother's health condition, her educational level, and economic status.

Almost every country has gone through a period of poverty and subsequent development, and it is important to learn from each other. Hanson (1986), for example, discusses our global responsibility towards child health, and presents the development in Sweden during the last 150-200 years, during which life-conditions have included poverty, hard work, bad health and low education, especially for women. The child mortality was high,

but is now among the lowest in the world, due to the eradication of poverty, ill-health, and illiteracy. Also Högberg (1983) discusses these pre-conditions in detail.

Many developing countries experience similar conditions, and in their cases there is also a rapid time-factor to take into account. Over-population, rapid population growth, and natural disasters worsen their situation, and getting rid of the poverty cycle is an almost unsolvable problem. They are particularly vulnerable during their transitional period from a traditional society to a modern one. The dialectical relationship between all basic needs, such as education, health, nutrition, shelter, clothing, and work, as well as the dimensions of society, like politics, economy and socio-cultural factors vary in kind and in time (Negussie,1988b).

Therefore, it is important to take existing knowledge into account. Each country has a valuable package of informal knowledge, often transmitted from generation to generation mostly between women. Nowadays, such knowledge also comes more and more into focus, as it contains many values, which are lost in the modern world. It is high time to learn about traditional child care, traditional child development and traditional child rearing, and to encourage our colleagues from developing countries to investigate and document their culturally-inherited knowledge. It gives us an important, missing piece in the child care puzzle.

2. The Ethiopian Experience.

Traditional maternity care and traditional child care have recently been studied in Ethiopia (Negussie,1988b). Information for this article is based upon such data, collected in the Southern Shewa region of south-western Ethiopia in 1985-87. These

data derive from a research project which focuses upon existing indigenous wisdom and knowledge among elderly women. The study emphasizes maternal and child care in general, and infant care in particular. It is based upon discussions and observations during several decades, when the researcher was able to live in the area during long periods. Background data and vital statistics for Ethiopia are presented in appendix I.

Ethiopia has experienced many changes during recent decades, including a shift from feudal rule to a provisional military rule (1974) to the People's Democratic Republic of Ethiopia (PDRE) in 1988. During this time there have been many shifts in the handling of social services, especially the change from a central administrative apparatus to a decentralized organisation with a new administrative organization of the regions (special autonomous regions, autonomous regions, and administrative regions, appendix II). There is then a regional responsibility for health and education, which in its turn should have a challenging effect upon the implementation of all programmes which benefit children.

3. Mother and Child Care in Ethiopia.

Mother and Child Health (MCH) is one of the priorities in Ethiopian health planning, clearly expressed by the Ministry of Health (MoH) and especially by the MCH-section (MoH,1978 EC = Ethiopian Calender; MoH,1988; Negussie,1988b). Mother and child care is, for example, listed in the 10 year health sector plan as one of the main target areas. It aims at a reduction of the infant mortality rate from the present level of 155/1000 to 95/1000; at the child mortality rate from the present level of 247/1000 to 150/1000, and an improvement of life expectancy at birth from the present 42 years to 55 years (MoH,1988). More

precisely, there are plans for strengthening and expanding MCH-services to benefit 80% of mothers and children under five years of age. Secondly, there are goals aimed at expanding programs on immunizations, nutrition education, et cetera.

The MCH-program has components, like the containment and prevention of common diseases, antenatal care, delivery services, postnatal care, family planning, vaccination of pregnant mothers and children, child health services (sick children, handicapped children, well-baby clinics, day care centers, kindergartens), school health services and health-nutrition education (MoH,1978 EC). Community-based MCH-services are being augmented by the education of community health agents and training of traditional birth attendants (Negussie,1988b). Health education concerning mother and child care is also included in the literacy programs, with translations to different vernacular languages. Educational Mass Media focuses upon this issue in radio and television programs.

3.1. Mothers in Southern Shewa.

Elderly women in Southern Shewa have sound knowledge about maternal health, handling deliveries, handling infants, feeding infants, and trado-pharmacological remedies (Negussie,1988b). The importance of proper diet is known, and it is crucial for a pregnant woman to have a psychologically and emotionally well-balanced experience. A mother shall "look at good things, experience good things, hear good things, and never be exposed to emotional shocks". Such beliefs are directly related to the health of the infant, which is believed to get its psychological character during its fetal period.

The delivery is a family event, when the expectant mother is the focus of attention from family and society. The birth of a child is important for the society as a whole, for the continuation of a lineage, and giving security to the parents. There are certain expectations for each child, regarding the preparation for his or her future position in society. Hence, both parents and the child are motivated towards a future career, either in the local society or within modern education and services.

Mothers play an important role as providers of health care for children. There are valuable traditional child care practices, such as keeping the infants warm, maintaining "on-demand breast-feeding" and methods for resuscitation (Ahlberg and Negussie, 1985, Negussie,1988b).

> A mother from this study described how her child had nearly suffocated from milk, stopped breathing and almost reached the stage of death, when the local herbalist brought a special root, pounded it and blew it into the child's nostrils. The child sneezed immediately and survived...

Such steznutatory remedies are not fully known, but need to be studied in greater depth. The decision about when to take a child to a health institution is usually made by the mothers. Having no means for transport it may include 2 days walk in order to get treatment.

However, there are also several harmful practices, such as cutting the uvula and teeth, and female circumcision. These practices are forbidden; hence also decreasing.

> In former times, there was a practice of giving a newborn infant a small amount of "k'ebe" (Ethiopian butter). The rationale was to clean and lubricate the digestive tract, but the side-effects caused the infant severe stomach cramps and diarrhea. A local laxantia, "kosso" (Hagenia abyssinica) was also used, resulting in similar problems.

Some ethnic groups practice early female circumcision (incision), which can cause urinary and gynecological problems for the girl's future life, and complications when giving birth. Mostly, though, circumcision in Southern Chad is performed during puberty. Numerous attempts are being made to eradicate female circumcision but many of them focus upon the medical hazards. The fact that the initiation period is an educational period is sometimes forgotten. The issue is sensitive, but needs to be handled not only by the health sector, but also by the educational sector and at an early age. Circumcision and other harmful practices are emphasized, and an educational and instructive program for traditional birth attendants and health personnel has been developed. The Inter-African Committee (IAC) deals with this issue in Ethiopia as well as in many other countries (IAC,1987). There is also re-education concerning nutritional taboos and early marriages. Since our conference deals with childhood up to the age of 6 years, it must call for the eradication of harmful practices in general, and early female circumcision in particular.

Male circumcision, is not considered harmful and is usually performed during puberty, being a passage rite from childhood to manhood. Several men describe their experiences, both regarding the discomfort, but also that it is important to endue the pain without any complaints. The circumciser's skill is more discussed than the pains. After his circumcision a boy stays in his mother's house for a couple of weeks, and is very well treated by her.

Some ethnic groups circumcise their boys already at the eighth day, and this circumcision is often performed in a hospital or in a clinic.

Nowadays it is also common to circumcise boys at the age from five to seven. It has become well-known that there is a risk of tetanus-infection, and young mothers prefer to get their sons circumcised by a health professional. Thus, circumcision is becoming an event during early childhood. A feast is celebrated also for these young boys, but much of the old, informal education is lost.

Women in Southern Shewa have a sound knowledge of diseases and symptoms of diseases (Negussie,1988b). The majority of them report diarrhea, vomiting, coughs, and throat infections are the most common and dangerous diseases, closely followed by colic (uncommon), cord infections, and eye infections. Traditional treatments exist, but usually the children are brought to a clinic for treatment. There are local concepts for a poorly-balanced diet (huffehel, which is an expression for undernourishment. There are also special ill-health conditions related to dry areas and drought areas. Their descriptions are similar to the concepts of marasmus and kwashiorkor (Negussie,1988b:187). Some contagious diseases are known, like measles and hepatitis. In mountainous areas there is an increase of respiratory disease, often with pneumonia as a complication. Symptoms of all these diseases are well-known.

Women's trado-pharmacological knowledge is much related to post-natal maternal care. The treatment of distended and swollen breasts reveals practices, which are found in literature as early as 78 AD (Dioskorides in Materia Medica). Women in Southern Shewa are mostly non-literate. Their medication is mostly inherited knowledge, transmitted through generations. Local pain-relieving remedies and anti-helminthic medicines are frequently used. The use of fenu-greek as a milk-producing medicine is common. There are, though, cases where it is used as a milk-substitute and a nutrient after delivery. Investigations show that its nutritional component is low, but its milk-producing effect needs more attention.

3.2. **Nutritional Customs.**

There is little attention to the preservation of beneficial practices. For example, there are many nutritional customs, which

are better for the child than the modern ones. The custom of using whole cereals and pulses are two examples which need to be reinforced in nutrition education. Breast-feeding is correctly practiced up to the age of almost three years, which is valuable both as a nutritional agent and for child spacing. This is evident in rural areas where breast-feeding is practiced "on-demand" and as long as the child wants. Weaning, though, is abrupt with the anointment of a sour or bitter plant juice on the nipples. The child immediately leaves its former sweet source of nutrition. The reason is often a new pregnancy, during which breast-feeding is considered harmful.

In families, where the older children (mostly girls) have started formal education, there is a clear tendency to take better care of the younger siblings. These children have a better chance to get proper, well-balanced supplementary food, and show a better health status than their own older siblings. Symptoms of disease are discovered earlier, and are better treated. Morbidity as well as mortality rates are lowered. The role of a girl's education is evident.

The use of pulses, notably, and fatty groundnuts is varied in our areas. In the area of this research it seems, though, that children in rural areas are better off than in semi-urban areas and urban slum areas. In these places, traditional practices blend with a striving for modern practices, though there is less access to the latter. Availability and economic constraints often cause mothers serious problems in feeding their children. Secondly, women are often involved in some kind of work, where they are forced to discontinue breast-feeding. Poverty drives them to buy cheap formulas and to dilute them too much. A less responsible baby care taker worsens the situation.

As concerns nutrition, there are various conditions, which relate to climate and living areas. In areas with dry and hot climate there are many difficulties in finding supplementary food and fluid. The scarcity of clean water-sources is the most evident problem. It is well-known that contaminated water causes diarrhea and vomiting, hence fluid is avoided and children become dehydrated. Breast-feeding is also insufficient, as mothers are undernourished and dehydrated. As a result, there is high morbidity and mortality in these areas. Elderly women, though, describe what they would do if conditions were normal. This indicates that the knowledge about proper nutrition is prevalent, even though the preconditions are absent.

> During the time for this research there were many opportunities to observe how people managed also during drought situations. An elderly women, for example, gathered many children in her kitchen, collected some grain and kale and gave them small portions each. Also children coming from far away got their share. The pot-makers, who usually exchanged food and clay-goods, had no possibilities to make any clay-pots, as there was no water. Therefore, they were often starving. This woman observed their harsh situation, called them, supplied them with some grain and told them that she had no use for any clay-pots at the moment, but that she would be delighted to get them a couple of months later (that was when the rainy season was expected to come). In this way she was able to help them without humiliating them.

3.3. Traditional Child Rearing Practices.

First hand observations indicate that small children are given much attention by parents, siblings, and grandparents. Mothers carry their infants on their backs, when doing their daily tasks. From his/her elevated position the child observes all events constantly, and as its needs are satisfied, it/she falls asleep, being close to the mother, rocked by her natural movements. A thin mantle covers the baby's head, preventing flies from attacking and the sun from penetrating. The mantle, though, is thin enough for the baby to look through. If the mother is

absent, there is always a sibling or other young child to replace her. A child is never left alone crying.

The close skin-to-skin contact renders the child warmth, but also creates a close relationship with the mother. Further, the mother can respond to the baby's signal for food immediately. She swings the baby to her breast, pays attention to him/her, and feeds him/her openly and frequently. Secondly, she observes toilet-needs at an early stage and treats them accordingly, by a quick swinging and providing relief for the child.

Grandparents play an important role as informal educators of small children. They are often day care-takers, especially for the first child, which is often fostered by its maternal grandparents. Tribal etiquette as well as health and nutrition is taught informally, and a tight emotional relationship is developed between the grandparents and the child. It is common to find a grandmother with two and three grandchildren sleeping with her, helping her and being cared for by her. Personal hygiene, bodily wash overs and proper feeding are usually performed by the grandmother.

During the first years of life the children play in the surroundings of their houses, constructing their toys with local materials. Often, they imitate adult life and produce toys which imitate tools used in daily life.

> A highly educated, middle-aged man described his first informal learning period as being one, in which he followed his father in his work. Among the first tasks was the herding of goats, in the close surroundings of the house. Having a stick instead of a spear gave him a feeling of having a weapon to defend his small herd. He learned his behavior from watching the older boys when they went and returned with the cattle-herds. By and by he then got the chance to follow some older boys to the grazing areas outside the plantations. Secondly, the father constructed small tools for the son, such as a small hoe, and then instructed him to imitate the father

when working. Ecological and practical agricultural knowledge was transmitted spontaneously.

Girls follow their mothers in a similar way, learning domestic chores, such as fetching water from the water-hole in a small claypot, carried in the same way adult women do. Girls also start to watch their smaller siblings at a very early age, carrying them on their backs and feeding them. Dietary knowledge, traditional health customs, and trado-pharmacological competence are taught at the same time. The evidence of poisonous plants is taught to children at a very early age.

There is a general comment that formal, modern education does not include such practical knowledge. Children, who are formally educated have little or no knowledge about traditional society, its rules, work, and expectations. Therefore, many educated children, who fail to get employment in the modern sector have difficulty in finding themselves useful in traditional society. On the contrary, they may even become a burden for their parents. The failure to integrate traditional societal knowledge with modern formal knowledge might, in the future, result in resistance to formal education.

3.4. Linguistic Competence and Training.

Women in Southern Shewa usually speak three or four languages fluently (Wegussie, 1988b:134-6). They shift easily from one language to another, and often speak one language with their husband, while using their mother tongue with their children. Children become bi-lingual (sometimes tri-lingual) at an early stage, speaking the mother's language at home, the father's with him, and sometimes a third language at school. Interpretation from one language to another are common. School-children also bring here and interprete school-knowledge to family members.

Since Southern Shewa belongs to one of the multi-lingual areas of Ethiopia, it is a necessity to handle several languages in society and in public places, such as markets, clinics, and in the administrative corpus.

4. Pre-school Education in Ethiopia.

Prior to the revolution in Ethiopia (1974) little attention was given to the pre-school program, although kindergartens and private pre-schools existed, but the national pre-school program has developed rapidly during the last fifteen years. The number of kindergartens increased from 7,570 in 1974 to 76,968 in 1987, a growth rate of 917% (Ministry of Information,1988:63). The urban dwellers' associations and the peasants' associations are helpful in the implementation of the pre-school program. The number of teachers for kindergartens has increased from 190 in 1974 to 1,685 in 1987.

A number of well-trained teachers graduate each year from a special training institute for pre-school teachers. Finally, the number of kindergartens has increased from 77 in 1974 to 803 in 1987 (Ministry of Information, op. cit.). Special consideration is given to children of the victims of war and disasters.

5. Conclusion.

It is evident that there is a strong relationship between health, nutrition and the early, informal education of children. This is true for Ethiopia in general and for Southern Shewa in particular. There are, for example, many examples from drought-stricken areas, where children who were undernourished and also never had any opportunity to learn, either informally or formally. Their weak physical constitutions prevented them from further development, and their life became a struggle for

survival without any incentives for intellectual development. Retardation became a daily reality, and mothers with apathetic children a common sight. These children seem doomed to a bleak life from birth.

On the other hand, Ethiopia shows many examples of positive relationships between health, nutrition, and education. As seen from the study in Southern Shewa, there are many well-nourished and healthy children also in remote areas, who perform very well in their formal education. The development of an administrative network with peasants', urban dwellers', youths' and women's associations all over the country also supports any efforts for the bettering of mothers' and children's conditions (Appendix I). In these associations, there are also many elderly, non-literate women who work together with younger, formally educated women. Together they plan for the development of a better peri-natal and early childhood environment for the children and their future. The discussion of eradication of harmful practices has reached also into remote areas with the help of well-developed network of radio-stations and broadcasts in several languages. The importance of breast-feeding is likewise practiced as being crucial for child development.

If existing self-care knowledge and informal, beneficial child rearing practices are taken into account, there will be a fundamental basis for future child development and educational achievement. If measures are adapted to each culture, their attainment is more readily secured because the people themselves will be in a better position to evaluate and use them. This will create a bright future for children in the 21st century.

Appendix I.

Current Data and Vital Statistics

Ia. Population projection (1988)

	Male	Female	Total
0 - 4 years	4 288 760	4 328 985	8 617 745
5 - 9	3 969 277	3 919 773	7 889 050
10-14	3 176 237	2 961 308	6 139 545
15-19	2 377 175	2 137 900	4 515 075
20-24	1 674 339	1 539 978	3 214 317
25-29	1 403 861	1 753 260	3 157 121
30-34	1 313 303	1 550 265	2 863 568
35-39	1 207 828	1 130 184	2 338 012
40-44	1 066 676	1 106 607	2 173 283
45-49	886 899	872 078	1 758 976
50-54	740 193	686 303	1 426 496
55-59	618 782	535 383	1 154 165
60-64	531 551	440 561	972 112
65-69	396 954	324 534	721 488
70-74	296 132	217 162	513 294
75-79	198 023	148 986	346 909
80 +	275 163	209 753	484 916
Total	24 303 154	24 372 924	48 696 078

Estimated annual population growth rate 1989-90 2.95%

Source: Addis Ababa: Central Statistical Office, 1985.

Ib. Vital Statistics (1987)

Crude birth rate	46.0/1000
Crude death rate	18.1/1000
Total fertility rate	6.1
Gross reproduction rate	3.2
Infant mortality rate	139/1000
Expectation of life at birth	48.5 years

Source: Addis Ababa: Central Statistical Office, 1987.

Ic. Organisational Structure of Peasants', Urban Dwellers', Women's and Youth's Associations.

National (Beherawi)

Regional (Mifi Ager)

Provincial (Awradjas)

Communal (Kebelles)

(A former district level (Woreda) existed, but is cancelled)

In 1985/86 there are 5,691,033 peasants' associations (PAs);
1,258 urban dwellers' associations;
3,740,276 youth associations (REYAs) and
4,917,347 women's associations (REWAs).

Source: Addis Ababa: Central Statistical Office, 1987.

Appendix II.

Map of the Ethiopian Regions.

Source: Ethiopian Government, 1988.

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